



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE METHODIST HOSPITAL
PO BOX 1866
FORT WORTH TX 76101

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-4726-01

MFDR Date Received

MARCH 24, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "TDI STOP LOSS RULE."

Amount in Dispute: \$81,478.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Correctly reviewed and reimbursed as trauma admission in accordance with admission diagnosis & documentation. Reimbursement correctly calculated as fair & reasonable, in accordance with TDI/DWC 134.401 c. (5)(A) & (6); ICD-9 diagnosis codes 800.0 – 959.50 are exempt from Stop-Loss methodology & entire admission shall be reimbursed at a fair & reasonable rate. Total payment \$40,062.89 determined to be in accordance with carrier standard & established fair & reasonable protocol for inpatient facility."

Response Submitted by: Claims Management, Inc., PO Box 1288, Bentonville, AR 72712

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2007 through July 20, 2007	Inpatient Services	\$81,478.36	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 19 – Claim/service lacks information which is needed for adjudication.
 - W1 – Workers Compensation State Fee Schedule adjustment.
 - 285 – Please refer to the note above for a detailed explanation of the reduction.
 - 295 – Service cannot be reviewed without report or invoiced. Please submit report/invoice as soon as possible to ensure accurate processing.
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - 849 – Inpatient allowance is based on a case rate established for specific diagnosis related group (DRG). The DRG rate is based on usual, customary and reasonable rates for the geographical area.
 - W10 – No maximum allowable defined by Fee Guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
 - 5036 – Complex bill – Reviewed by Medical Cost Analysis Team.
 - 5080 – Reimbursed to fair & reasonable.
 - 11 – The recommended allowance for the supply was based on the attached invoice.
 - 13 – An additional allowance has been recommended for implants/prosthetics.
 - 101 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when “Trauma (ICD-9 codes 800.0-959.50)” diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 928.10. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor seeks the Stop-Loss 75% reimbursement of billed charges based upon “TDI STOP LOSS RULE.”
 - The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states

that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	December 6, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	December 6, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.